Moving Hospital Partnerships Forward

Nine SNF Executives from Across the Nation Speak Out

Executive Roundtable

American Healthcare Association Annual Convention

October 10, 2012

American HEALTHTECH
Post Acute Care
Information Technology

Executive Summary

"There used to be 50 facilities taking Medicare patients in San Diego County. Now there are 5."

Kenneth Lund, CEO
Shea Family

The Challenge

As their revenues get squeezed, hospitals' post-acute partners are more important than ever in the fight against unnecessary readmissions to protect their top line. In October of 2012, nine providers from across the country came together at AHCA's Annual Convention in Tampa to share experiences, strategies, and advice in a roundtable about moving hospital partnerships forward.

The Bottom Line

If you depend on Medicare revenue today (and increasingly Medicaid in the future), you must collaborate with your hospitals to attack this problem … or watch census dry up. Hospitals are shopping markets for post-acute providers with the most attractive, data-driven outcomes. Data, collaborations, and new processes to achieve results are taking center stage.

The Takeaway

This paper summarizes what these nine providers are doing to energize hospital partnerships. Their top discussion points:

- Find a common set of metrics to measure performance
- Increase communication at the right level
- Smooth transitions from hospital to facility to home
- Maintain independence – but win the business
- Engage physicians to negotiate on your behalf
- Get systems to share data, trend, and track outcomes

Roundtable Participants

Robin Allen	Vice President of Risk Management, Cypress Health Group, Sarasota, Florida
Chris Bryson	Chief Operating Officer, UHS-Pruitt Corp., Norcross, Georgia
Bill Hartung	Data Analytics Director, MediLodge Group, Washington, Michigan
Mary Jo Kurtz	COO, Van Dyk Health Care, Ridgewood, New Jersey
Lance Long	Vice President of Clinical Services, American Health Care, LLC, Roanoke, Virginia
Kenneth Lund	President & CEO, Shea Family, San Diego, California
Lannie Richardson	CEO, Central Control, Pineville, Louisiana
Meera Riner	Senior Vice President of Operations, Nexion Healthcare, Sykesville, Maryland
Marc Rothman, MD	Chief Medical Officer, Kindred Healthcare, Louisville, Kentucky

American HealthTech was represented by President and CEO, Teresa Chase and Vice President of Sales and Marketing, Devin Simmons.

The Moderator

Joanne Erickson, Editor In Chief, *Provider Magazine*

"The hospitals have data that is completely different than ours. They trust their data."

Chris Bryson, COO
UHS-Pruitt Corp.

What criteria are hospitals using to compare providers?

Key Discussion Points

- Hospitals and SNFs have different data; causes disconnects
- Decisions are data-driven
- Data one hospital wants may be totally different than another

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[Lund] During the last six to nine months, the market has grown to be more **analytically driven**. Hospitals are looking at readmission rates and Five-Star ratings — starting out with longest Medicare stays.

[Rothman] Our experience is local and varied. There is some acknowledgement that **hospitals don't know our world**. They always start out asking about the re-hospitalizations, but we end up talking about what drives quality in nursing homes. The conversation never starts with questions about quality.

[Riner] In East Texas, our experience is varied, as I don't think most knew anything happened on October 1. But, we have had hospitals fax us a post-readmission clinical tool that we had to complete for every patient. Our hospital has been on my case about readmissions. I sat down with them and said, "**Let's look at the data for the last six months."**

[Bryson] We've been talking with hospitals for years and have their DRG data, and I felt like we knew more than they did. But now, **the hospitals have their own data that**

> "Our data is not their data."
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> *Lannie Richardson, CEO, Central Control*

is completely different than ours. We are looking at our admission and re-admission diagnoses and not necessarily the hospital's admission and discharge DRG's. They only trust their data. But they are starting to learn a little more about us. We are still far apart, but we're getting there.

[Richardson] Yes, **our data is not their data**.

[Long] We are in a rural area. When the hospital's census falls, all of a sudden everyone is "under an observation period." Rural hospitals are more concerned about census and length of stay rather than hospital readmission rates or outcomes data.

October 10, 2012 – AHCA Executive Roundtable, sponsored by American HealthTech. Photo courtesy of AHCA.

Do requirements differ?

"Sometimes hospitals – or their competitors – want to label a nursing facility as "their building" because their doctors are going there many times a week."

Mark Rothman, MD,
Chief Medical Officer
Kindred Healthcare

Key Discussion Points

- Hospitals wanting exclusivity is on the rise
- Competition for census is increasing
- Physician affiliation with hospitals drives referrals

[Kurtz] If you align yourself with one hospital, you have to be careful about aligning yourself with another. If you develop a really good program, the surrounding hospitals want to know what's in it for them. Case managers are dealing with the Five-Star report.

[Lund] Hospitals are saying they may want to private label your building, creating conflict.

[Rothman] Certain hospital systems in certain markets are very competitive. Sometimes hospitals – or their competitors – want to label a nursing facility as "their building" because their doctors are going there many times a week. Then word gets around, and that makes referrals from other sources more challenging.

[Lund] Some are asking for office space in the facility.

[Long] In Virginia Beach, we had two medical directors, one aligned with the local 800-pound gorilla, and another aligned with its 700-pound brother. One is for profit, the other non-profit. And, **we cannot get in either hospital unless the doctors treating our residents in our facility are affiliated with one or both of them.**

Are your outcomes getting traction at the negotiating table?

"With hospitals, if you fall outside of a certain range with Five-Star, the contract is null and void. They'll go elsewhere."

Kenneth Lund, CEO
Shea Family

Key Discussion Points

- Use Medical Directors to get attention at the negotiating table
- Share outcomes and transition data to improve relationships
- Organize a collaborative action plan
- Differentiate with a niche that is attractive
- Expand services to meet needs for disease management

[Lund] Hospitals want length-of-stay, Five-Star, and readmissions data. For us, it's, "what are we doing beyond that?" We've centralized and created a single point of entry for patients. Whatever service they need, we figure out how to provide it.

[Riner] With readmissions, we hear, "what are you guys going to do?" Also, it has been suggested that we purchase a portable EKG unit. In North Texas, some hospitals want a dialogue about CHF and COPD patients and to write protocols together. It is very positive, but different and all over the place. They are looking at readmission rates**. If it's low, they will work with you. If it's high, they will not.** We're taking that to them to make them more aware and educate them on all the different components.

[Rothman] The quality equation cannot be reduced to a single number or metric. **Quality is multifactorial**, and hospitals don't always appreciate that. So we try to show them the multiple aspects of quality – survey

"We must have outcomes data and be able to present to both CEOs and discharge planners"

Chris Bryson, Chief Operating Officer

results, staffing, rehab outcomes, etc. So, getting ready for hospital meetings can be really difficult. It can take hours. I'm working on a system to make it easy. With a push of a button, we can be ready for meetings, and shouldn't need to reinvent the wheel every time.

[Lund] We are creating portals and dashboards for the hospital system and their physicians to share and jointly manage these and other data points. With hospitals, if you fall outside of a certain range with Five-Star, the contract is null and void. **They'll go elsewhere.**

[Bryson] Would be great to get traction with hospitals, but we're finding that they really don't care. They want to look at the data they're being fed. It seems like every CEO of a hospital hears [a horror story] about one patient that wasn't even our patient, and holds us down by this one negative example. They don't trust us. And when we get through to a CEO, they don't necessarily communicate down to their discharge planners. **We must have outcomes data and be able to present to both CEOs and discharge planners** to demonstrate objective quality outcomes and dispel rumors.

[Riner] Our medical directors are very powerful. We're educating them and also investing more time with our doctors so that when they have the opportunity to bend the ear of the hospital CEO, they can then educate them. **I find that educating doctors at our level is more powerful than going to the CEO ourselves.** The CEO's will say, "eight years ago…something (negative) happened." They are very focused on what they have in front of them. At the end of the day, we're educating docs because they are getting pressure from hospitals

"If you want to be more respected, act more professional."

Lannie Richardson, CEO, Central Control

and pressure from us to increase census. I take them with me to a meeting with the hospital CEO.

[Allen] Hospitals are asking for our medical directors to be present at the meetings.

[Rothman] Sometimes I push back on the hospital and say, "You want us to fix re-hospitalizations…but half of the problem might be yours too." Their discharge and transitional care practices are not pristine, either. So, we need them to invest resources as well.

[Lund] Hospitals want to put their doctors in our buildings and that's contributing to reducing readmissions by 50%.

[Richardson] **If you want to be more respected, act more professional** — we're making an effort. Our nurse practitioners are making rounds in the hospitals and come back and report. Our activity is more like a health care facility rather than a custodial care facility.

[Kurtz] When meeting with hospitals, **you need to find the piece that differentiates you**. Our cardiac nurses making follow-up visits is of interest to hospitals.

[Lund] We started a transition program in January where **case managers and transition people work collaboratively**.

[Bryson] Urban hospitals are more prepared; they have transition managers and strategies in place to fix and track data. However, our rural hospitals now seem much more willing to be innovative. Their nurses are coming to work with us and we're sending our nurses there. And, they are allowing us access through portals so that we can track our patients.

"We need to get to a place where we are speaking the same language and looking at the same data."

Meera Riner

Senior Vice President of Operations

Nexion Health

What makes a successful partnership?

Key Discussion Points

- Be ready to be measured against others to win census
- Train staff to accept specialized patients
- Align admissions and discharge processes to go beyond the hospital and SNF to include home health

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[Hartung] You have to be willing to accept patients. If we're willing to take a hospital's patients, they are willing to work with us. Many hospitals are saying that they have twenty SNFs from which to select for discharges, will select five, and the other fifteen are out. **The hospitals want a solution**. We are really early in this process. **We have to step-up with the services we are providing.**

[Rothman] When hospitals look at how many SNFs they're sending patients to, they realize that they don't need to send to so many. **Most of the hospitals we are speaking with say about five to ten would be ideal.**

[Riner] They pick standard traits that SNFs offer in care and then identify ten SNFs to work with. ACOs are shocked when they find out they're sending patients to 38-50 buildings.

[Lund] There used to be 50 buildings accepting Medicare patients in San Diego County. Now there are five. ACOs have forced a consumer's mentality on this. Care transition programs are increasing from 30 days to 12 months.

"When hospitals look at how many SNFs they're sending patients to, they realize that they don't need to send to so many."

Mark Rothman, MD, Chief Medical Director

Kindred Health Care

[Long] The only way to stay alive is to be able to take anyone anytime, which leads to more training of staff.

[Bryson] We need to align the admissions and discharge processes. The patients coming to us are higher acuity and discharged earlier from the hospital. As we discharge out of our building to home health, it is our responsibility to make sure our patients have received enough rehabilitation to safely transition to a home environment.

Processes across the continuum need to be challenged. We complain when hospitals discharge to us too early…but we do the same thing to home health by discharging our patients before they are ready to go home. When it comes to readmissions, home health and SNFs are the same, the majority are going back to the hospital within the first seven days. We need to fix it ourselves.

[Lund] If you had a single clinical system, would that significantly improve that issue?

[Bryson] Yes.

[Lund] We created a **central intake system**.

"Getting ready for hospital meetings can be really difficult. It can take hours..."

Mark Rothman, MD, Chief Medical Director

Kindred Health Care

Are you seeing bundling or value-based purchasing programs?

Key Discussion Points

- Adapt to what hospitals are doing to keep programs affordable
- Get ready to survive with fewer resources
- Get ready for confusion about how care is financially covered

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[Hartung] Two hospital systems initiated participation in a demo with CMS' Center for Medicare and Medicaid Innovation (CMMI). One reason to participate was to begin open and honest conversations with other providers about care transitions. We have a major hospital that invited two of our facilities to join the demo. So, we considered a bundling proposal on the PAC side. The CMMI proposal is for a very limited scope of DRG. I'm anxious to see what comes back.

[Rothman] Kindred has submitted a bundled payment application to CMMI for cardiopulmonary DRGs in the Cleveland area. And, two of our facilities are included in the CMMI NF-Initiative to reduce hospitalizations at the Indianapolis site. We will learn a lot from the bundling project, but the reimbursements are unfavorable either way.

"If you think being a custodial provider will make you, you're wrong."

Kenneth Lund, CEO
Shea Family

[Lund] We're at the mercy of what the hospital dictates. Forced consolidation is likely to happen among smaller providers because they don't have the resources to adapt to what hospitals are doing. I openly say, skilled nursing is dead; if you think being a custodial provider will make you, you're wrong.

[Richardson] The other day, one hospital attempted a discharge from a critical care unit (CCU) to a SNF.

[Long] They do not care or understand what we do on our side.

[Rothman] Hospitals want to isolate a patient who is ambulatory, but they don't want to hear about patient rights. That's beyond my pay grade. What we have creates a new LTAC model. We said to all SNFs in the area, if you want something urgent or a procedure done by gastro, or a new Denver drain for a patient, you can send the patients to us. Call, and we'll get a nurse downstairs. We'll do what you want and leave the decision making to you. It avoids the ER chaos. That's a cool thing. We're trying to replicate it in Boston…avoid the ER and, possibly, a readmission.

[Richardson] We are **partnering with the hospital** to track cardiac patients.

What tools look promising?

"We're educating families about why it's best that we keep patients in the facility."

Mary Jo Kurtz, COO
Van Dyk Health Care

Key Discussion Points

- Implement INTERACT II™ to combat readmissions
- Educate and involve families
- Consider telehealth to improve family communication
- Engage physicians with outcomes reports

[Riner] INTERACT II is another tool we use. Also, thanks to suggestions from AHCA, we came up with a triage: track our at-risk patients, have a clinical discussion, and look at high risk areas. **We're tracking who is going to the hospital and why they are going**. We assess 24, 48, and 72 hours after admission. I think we're staying ahead of those kinds of things, whether it's a way to provide better feedback to an on-call doctor on weekends, or a call to the DON, we're letting them be involved. That has helped some. The last data I pulled, our re-hospitalization rates were improving. We use analytics to drill down by shift, doctor, etc.

[Kurtz] **Family involvement and re-hospitalizations** — because families are demanding…we're educating families about why it's best to keep patients in the facility.

[Richardson] Coming from the hospital environment, where people swarm around them, families see nursing homes as places where people are not around and therefore think that the quality is not as good.

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> *Meera Riner, Sr. VP of Operations*
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> *Nexion Health*

[Riner] We have to tailor our discussion with [hospitals] to be more aware and alert of possibilities and scenarios during transitions.

[Richardson] Nurse practitioners meet with families on the first day, explain the stay, and talk about process. In two years' time **we reduced readmissions from 28% to 14-15%**.

[Rothman] We are using the **INTERACT program** in all our centers nationwide. And we are revising our 30-day re-hospitalization calculations to ensure that every discharge to a hospital is captured, even if it is the same person being re-hospitalized again and again. "Frequent fliers" are an important part of the issue, and we don't think that should be hidden.

We're creating a **quality report for all SNF physicians** that will show their re-hospitalization and discharge-to-community rates, as well as other clinically relevant metrics. And we are going to pilot a telemedicine solution in certain markets. I think **telemedicine** visits with families would make a big difference. It's a cheap, affordable way to put family and doc in front of each other. It has the potential to make a huge difference.

About American HealthTech

American HealthTech is **Your Ultimate Connectivity Partner,** connecting caregivers, partners, and healthcare networks to drive higher outcomes in the new era of post-acute care. Coast to coast, a fifth of the nation's providers depend on AHT daily for innovations that free hands to care for others. For more information, visit www.healthtech.net.